HealthPath Washington

9/6/2012

Answers may need to be revised based upon the State Plan Amendment (SPA) negotiation process with the Center for Medicare and Medicaid Services (CMS).

Health Home Services	
What services will be provided by a Health Home?	A health home network provides six services identified in section 2703 of the Affordable Care Act. A health home is qualified by the State and is responsible for the integration and coordination of primary, acute, behavioral health (mental health and substance use disorder) and long-term services and supports for high cost/risk persons with chronic illness across the lifespan. Health homes services cannot duplicate other care management or care coordination services provided under Medicaid. The following services are provided by health home care coordinators. • Comprehensive care management • Care coordination and health promotion • Comprehensive transitional care and follow-up • Patient and family support • Referral to community and social support services • Use of information technology to link services, if applicable
How are Health Homes different than the services we have in place now?	The health home care coordinator will use PRISM, health screening and engagement of the beneficiary to identify the root causes for inappropriate or gaps in health care utilization. The Health Home care coordinator assesses client activation levels through administering the Patient Activation Measure (PAM) tool. Information is used to work with the beneficiary in developing a person-centered health action plan that contains beneficiary driven goals to improve health and ability to self-manage chronic conditions. The health home is accountable for reducing avoidable health care costs,

	specifically preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post discharge follow-up, and improving patient outcomes by addressing health care needs.
Does the State intend to identify and credential providers, or will identification and credentialing be the responsibility of the Managed Care Organization or health home lead organization?	The state will qualify health home networks which include the lead entity and community based care coordination entities. The qualification process will be formalized through a "Request for Application." The state expects to release the application in the fall.
How does the state plan to sustain this effort once the CMS 2703 funds end?	The project will need to achieve performance outcomes to sustain health home services.
Health Home Qualification and Networks	
Will Health Homes be certified by the State?	No. Health Homes will be qualified by the state.
Who will be the agency responsible for the qualification process?	The Health Care Authority and the Department of Social and Health Services will be jointly responsible for reviewing and qualifying health home network applications.
Will there be a maximum number of Health Homes in an area/county?	Yes, there will be a limited number of qualified health homes in a geographic area. We have not yet determined that number.
What will Health Home Networks look like?	Health Home networks must include a wide range of community partners to serve the diverse need of high cost/high risk beneficiaries that meet the standards determined by the state. Networks must also be able to provide services throughout a defined geographic region, include in its network providers who have experience and expertise providing services to high cost/high risk beneficiaries and have the capacity to provide health home services to at least 1,000 clients
What type of organization can be qualified as a Health Home?	There is no single entity that we foresee at this point in time that would by itself qualify as a health home. Qualification requires a community based network that is able to integrate services across the service domains needed by high cost/high risk clients including medical, long term services and supports, mental health, and chemical dependency. Individual organizations will not be qualified. The State will qualify a limited number of health home networks that meet the qualifications requirements.
Why should organizations consider participating in a Health Home network?	Fragmented and uncoordinated care across service domains and funding streams is a long standing problem that leads to poor health

	outcomes, gaps in care, individuals falling through the cracks when transitioning from one care setting or provider to another, duplication of services and avoidable health care costs. The implementation of health homes is an opportunity to provide intensive care coordination and integration of service delivery that supports individuals in managing their chronic conditions, improving health outcomes and impacts of chronic disease and reducing avoidable health care expenditures. Participation in health home networks provides an opportunity to be at the forefront of an important health reform initiative.
What will be required of Health Homes to show their networks are in place?	This will be detailed in the application process which will be released in October.
Will there be multiple networks in the same community?	The state will limit the number of health homes, but there is likely to be more than one health home in a community. Organizations that agree to provide the care coordination services may elect to participate in more than one health home.
How is the state going to recruit organizations for Health Home designs to ensure geographic and demographic coverage?	The state initiated a letter of interest process for health homes to identify interested organizations. The state will be hosting regional forums in the fall of 2012. These forums will be designed to facilitate collaboration and partnerships to assure geographic and demographic coverage. The state intends to implement health home geographically as networks are qualified.
What will the protocol be if a provider within the Health Home network refers a member to a non-Health Home provider?	One of the health home services is referrals to needed services. Not all Medicaid providers are expected to be part of a health home network. Health action plans and coordination is anticipated to occur with any provider the beneficiary identifies as part of their care team.
If Health Homes are a network, what will be the requirements for the overarching entity that maintains the network?	This entity will be known as a Lead entity. Lead entities will be responsible for administrative functions that need to occur with network partners, including payment disbursement, contracting, data collection and reporting, quality metrics reporting and quality oversight.
Health Home Lead Entity	
What is a Lead entity and what are their responsibilities?	Lead entities will be responsible for administrative functions of the

	health home entities within the network including payment disbursement, contracting, data collection and reporting, quality metrics reporting and quality oversight. A small portion of the per member per month (PMPM) payment may be retained by the lead entity to support administrative functions. The state is currently working with an actuarial firm to establish the administrative rate within the payment.
What are the advantages of being a Lead entity?	The lead entity is going to have a lot of administrative responsibility associated with data, reporting, contracting, payments, etc. There are natural community entities that have the administrative capacity and sophistication to be able to do those administrative functions. Motivating factors for being a lead entity may include being at the forefront of integration efforts, providing community based coordination and leadership functions in support of health home activities for high cost/high risk beneficiaries in the local community.
Since Health Homes are designed to integrate medical and social supports for eligible individuals, is the medical provider or community provider in the best position to become a lead entity?	The lead entity must be able to demonstrate the capacity and expertise to perform the administrative functions required by the lead entity. This will likely vary by geographic area
How will a Health Home Lead be paid and how much will they be paid	The lead entity will receive a PMPM payment in months where a health home service is provided to an enrolled beneficiary. A small portion of the PMPM payment may be retained by the lead entity to support administrative functions. The state is currently working with an actuarial firm to establish the administrative rate within the payment.
In the Qualification and Standards document, it states that lead entities must have an NPI on file. What is an NPI?	NPI stands for National Provider Identifier. NPI is a CMS federal regulation designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard.
Who qualifies for an NPI?	All individual HIPAA covered healthcare providers (physicians, physician assistants, nurse practitioners, dentists, chiropractors, physical therapists, etc.) or organizations (hospitals, home health care agencies, nursing homes, residential treatment centers, group practices, laboratories, pharmacies, medical equipment companies, etc.) can apply and obtain an NPI. All standard HIPAA transactions must have an associated NPI.

Health Home Information Technology and Assessment	
Is access to PRSIM considered sufficient Health Information Technology? If yes, will PRSIM access be granted to the Health Home lead once an application is accepted?	No, PRISM is just one of many Health Information Technology (HIT) tools that will be used to identify gaps in care and determine where avoidable utilization of emergency room, hospital and institutional care is happening. The network must use data systems to collect, analyze and report financial and health status outcome performance measures, establish protocols to share usage of emergency room visits, inpatient hospitalizations, missed prescription refills and the need for evidence-based preventative care.
Will there be a uniform health assessment tool?	Yes, the state will establish requirements for the use of standardized and evidence based/informed screening tools. Standardized screens will be required for: • Depression using the PHQ-9 • Falls risk (tool to be determined) • Pain assessment (tool to be determined) • Alcohol and chemical use using GAIN-SS • Functional impairment (tool to be determined) • Patient Activation Measure using the Insignia data base
Who will review and approve the health assessment tools?	The health assessment tools will be approved by DSHS and HCA.
Does the state intend for Managed Care Organizations to build HIT functionalities that will connect all specialties or can the MCO coordinate care via alternate channels?	Any organization that takes on the responsibilities of the lead entity must have mechanisms in place to collect and store health care data and methods to share that data under a secure system. That may be achieved via alternative channels.
Who will be responsible for tracking the selection, enrollment and disenrollment of beneficiaries within Health Homes?	Enrollment into a health home will be an automatic process with an opt-out feature. Enrollment notification is sent to the lead entity through an automated 834 HIPAA compliant transaction. Once the beneficiary is enrolled, the lead entity will be responsible for assigning the beneficiary to one of their contracted care coordination organizations, either through a “smart” assignment process or beneficiary choice. A “smart” assignment can usually be determined by examining claims or encounter data to establish the provider the beneficiary sees the most often.

	Beneficiaries may voluntarily disenroll from a health home by calling the Health Care Authority's toll-free line and asking for disenrollment.
How will systems be set up so that data exchange is seamless between Health Home networks?	This will be an on-going process as Health IT systems are developed.
Health Home Performance Evaluation	
How will monitoring and evaluation of health Homes work?	There will be evaluation at the state and national levels and a standardized set of performance measures. The details of the evaluation are under development with the Center for Medicare and Medicaid Services. The state will delegate a portion of the evaluation and monitoring process to the Lead entity and provide oversight and technical assistance on that process.
Who will be monitoring all the component providers in the Health Home?	The State will have some oversight and some will be delegated from the State to the lead entity.
Will the State require a specific set of guidelines?	Yes
What are the evaluation measures?	The state specific evaluation measures are: • Decrease emergency room visits for ambulatory care-sensitive conditions • Decrease skilled nursing facility placements • Reduce hospital readmissions • Decrease selected ambulatory care-sensitive condition admissions for Diabetes and adult asthma. • Follow-up after hospitalization for mental illness • Increase percent of enrolled health home beneficiaries who set a health action goal • Increase average "Patient Activation Measure" (PAM) of participating health home beneficiaries • Increase screening for clinical depression • Measure the initiation and engagement rate of alcohol and other drug dependence treatment
Will the measures be consistent with measures currently reported in	Some measures are consistent with HEDIS standards, but not all

other HCA programs, such as HEDIS measures?	measures are from HEDIS. When designing the state specific measures, only those that were collectable through claims, encounter data or health enrollment data were included in the State Plan Amendment. The CMS required Health Home Core measurement set and CMS required the Managed Fee-for-Service measurement set are closely aligned with the National Quality Forum recommendations but not all the CMS required measures can be derived from encounter or claims data.
What guidelines will be used to assure the receipt of evidence-based care?	Practice guidelines should be from nationally accepted sources, such as Agency for Healthcare Research and Quality.
Who is accountable for utilization management decisions and where does the risk, accountability, and liability lie, with the health home lead organization or contracted providers?	Authorizing entities are responsible for utilization management decisions and accountability for delivery of the services resides in those entities providing authorizations, direct services and treatment. The health home care coordination services do not require prior authorizations. To ensure that care coordination is an active, high touch benefit, the state is discussing a performance based payment mechanism, in the form of a small withhold. Those funds would be returned if selected measures are met.
Will the State directly monitor some portion of the client's plan and client outcomes for health home contractors, how intensive and frequent would this monitoring be?	There will be monitoring and program review of health home networks and services. Outcomes will be measured as part of the national and state program evaluation activities.
Health Home Payment	
What is the payment structure for Health Homes?	We are anticipating 2-3 tiers in the payment methodology that vary based upon intensity of the intervention expected. The PMPM rate is anticipated to be between $140-$180 at the highest tier.
How will payment mechanism work?	The payment mechanism will be based upon submitted encounters.
Under Managed Care, will the payment be built into the PMPM rate?	Yes
Will the plans receive payment regardless of services delivered?	No.

How will payment be adjusted when beneficiaries decline service?	Health home services under 2703 funding can only occur when an eligible and enrolled beneficiary receives a qualified health home service. If a beneficiary declines a care coordination service, then no encounter should be submitted.
If the Health Home is not managed by a MCO, will there be funding for start up costs?	There is no funding for start up costs in either the MCO or fee for service health home networks.
Will all organizations that are a part of a Health Home network receive payment?	No. Organizations that are contracted to provide the six care coordination services will receive the bulk of the payment, with a small portion dedicated for administration of the program via the lead entity. HCA and ADSA are currently in discussions with the actuarial firm of Milliman to determine the most appropriate distribution of health home funds and that may include a performance based payment mechanism, in the form of a small withhold.
Will Health Home network providers be at financial risk with Capitated reimbursement, risk corridors/risk adjustment, or would they operate on a fee-for-service?	Health homes services for dual eligible will be provided on a fee for service basis and may include a performance based payment mechanism, in the form of a small withhold.
Health Homes and Beneficiaries	
Will beneficiaries have a say in the services they receive?	Yes. We believe that beneficiary choice is a big piece of health home service delivery success. Beneficiaries will be able to choose among qualified health home care coordination organizations within a health home network. Health action plans are developed with active participation and agreement of the beneficiary.
Who will help beneficiaries make decisions about which Health Home to participate in?	The state will automatically enroll beneficiaries into qualified health home networks based upon capacity and service areas. Individuals have a choice of whether or not to receive health home services and may disenroll at any time. If a beneficiary does not disenroll and does not want to receive services, that beneficiary will not count against the 50 to 1 care coordinator to beneficiary ratio. Once the beneficiary is enrolled, the lead entity will be responsible for assigning the beneficiary to one of their contracted care coordination organizations, either through a “smart” assignment process or beneficiary choice. A “smart” assignment can usually be determined

	by examining claims or encounter data to establish the provider the beneficiary sees the most often.
Will beneficiaries be locked into a Health Home?	No, beneficiaries cannot be locked into a health home. Beneficiaries will be automatically enrolled in a health home with the option to "opt-out" and may disenroll at any time. CMS does not allow mandatory enrollment in a health home under section 2703 of the ACA. Beneficiaries must consent to receiving health home services. To be successful in achieving the outcomes, beneficiaries must be engaged in determining their health action goals and making the behavior changes necessary to work toward those goals.
How will beneficiaries know where to go to "enter" the Health Home network?	The state will assign eligible beneficiaries to a qualified health home network. Outreach and education materials will be developed to assist beneficiaries in learning about health home networks.
How will consumers/beneficiaries be informed and educated on Health Homes?	Participation in a health home will be voluntary on the part of an eligible beneficiary. The state will be developing outreach materials and informational materials that will be sent to individuals who are eligible for health home services. We also anticipate referrals to health home networks from organizations that work with this population as well as self-referral from beneficiaries.
Who will choose a beneficiaries' Health Home Care coordinator?	Health Home care coordinators will be embedded in one of the Health Home's contracted care coordination organizations. Once the beneficiary is enrolled, the lead entity will be responsible for assigning the beneficiary to one of their contracted care coordination organizations, either through a "smart" assignment process or beneficiary choice. A "smart" assignment can usually be determined by examining claims or encounter data to establish the provider the beneficiary sees the most often. Once assigned to a care coordination organization, a process must be in place to allow a beneficiary to select their care coordinator.
Will a beneficiary have more than one Health Home Care Coordinator	No. Beneficiaries will have one Health Home care coordinator.
How many beneficiaries will Health Home Care Coordinator support?	The standards require an average beneficiary to Health Home care

	coordinator ratio as 50 to 1.
Who determines the level of care coordination a client receives?	All six Health Home care coordination services are part of the health home benefit and a beneficiary should expect to receive those services during active care coordination. Care coordination will likely be handled by definitions, expectations and eligibility criteria the state will establish. The health home is expected to coordinate services across service domains and work with the beneficiary to establish health action goals, coordinate with the beneficiary, their family and their care team to assist in achieving health action goals.